DC State Innovation Model

Better Health Together

Medical Care Advisory Committee Meeting

SIM Update

May 25, 2016

SHIP Development Process

Stakeholders

Payment Model

Care Delivery

HIE

SIM Advisory Group

Quality Measurement

Community Linkages

DC's State Health Innovation Plan

Consumer Interview Results

PATIENT EXPERIENCE

~30% of surveyed Medicaid beneficiaries do not understand their benefits & would like more education on the benefits they are provided

Patient education on healthy eating & healthy living habits would be the most helpful services to manage chronic disease

EMERGENCY DEPT. UTILIZATION

Participants in hospital emergency departments (ED) were less satisfied with their PCP & were more likely to use ED services before calling their PCP

Chronic pain is the most common cause for ED visits among the sample population (accounts for 44% of ED visits discussed during survey)

GAPS IN CARE/SERVICES

Access to timely primary care appointments; availability of dental/vision care were the most common gaps in health services identified by respondents

Housing & food insecurity were the most common social service gaps among respondents

Consumer Focus Group Results

PATIENT EXPERIENCE

Participants did not understand Medicaid covered benefits

Beneficiaries value independence & feeling control of their life and health

The Ombudsman is a valuable resource for beneficiaries; those that contacted the Ombudsman are satisfied with their resolution

Feelings of mutual trust and respect with providers have a great impact on when and how often individuals seek care from that provider

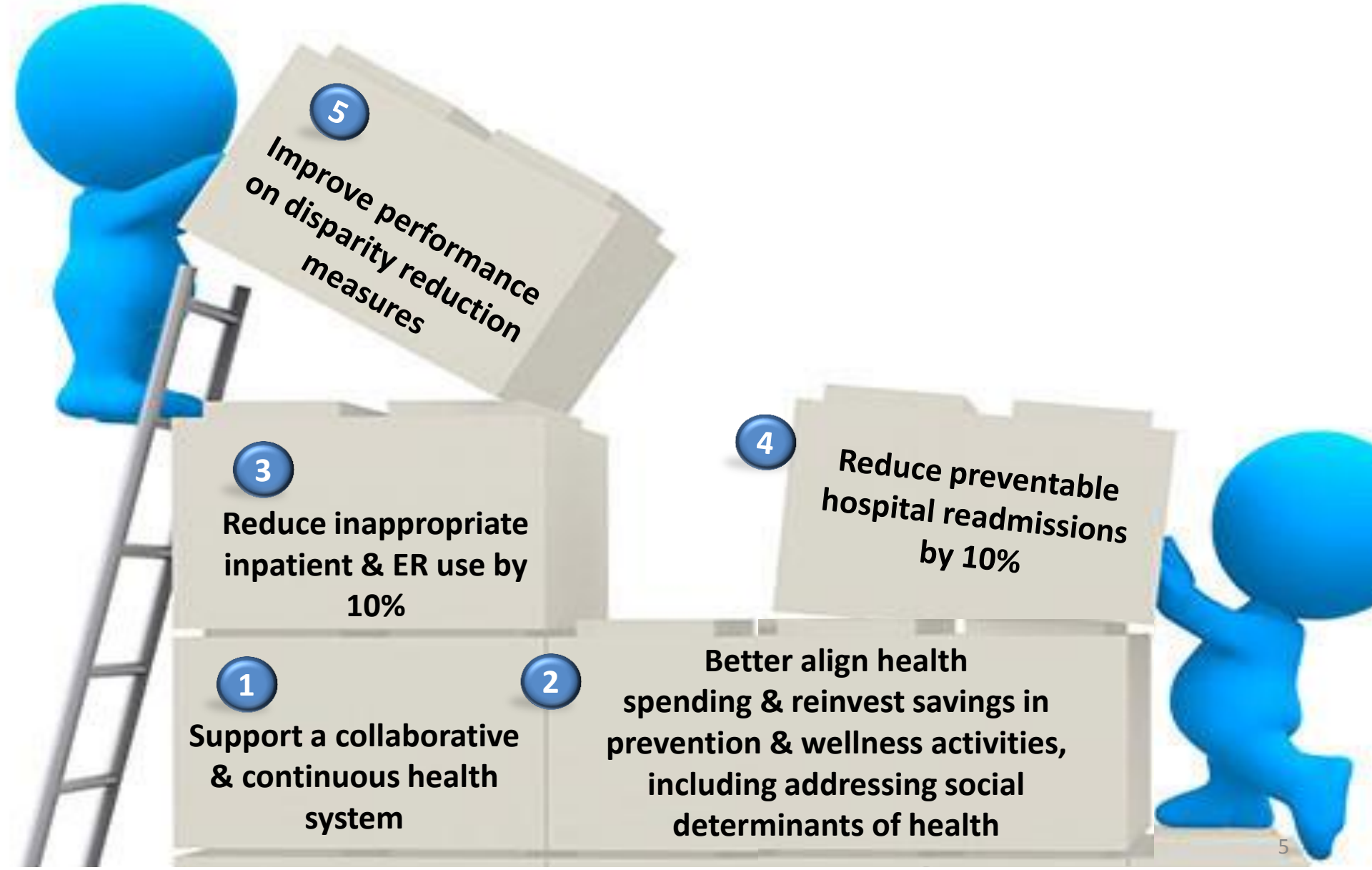
Office staff are a significant part of the healthcare experience; Patients reported not calling office for advice on visiting the ED when they were unsatisfied with the office staff

GAPS IN CARE/SERVICES

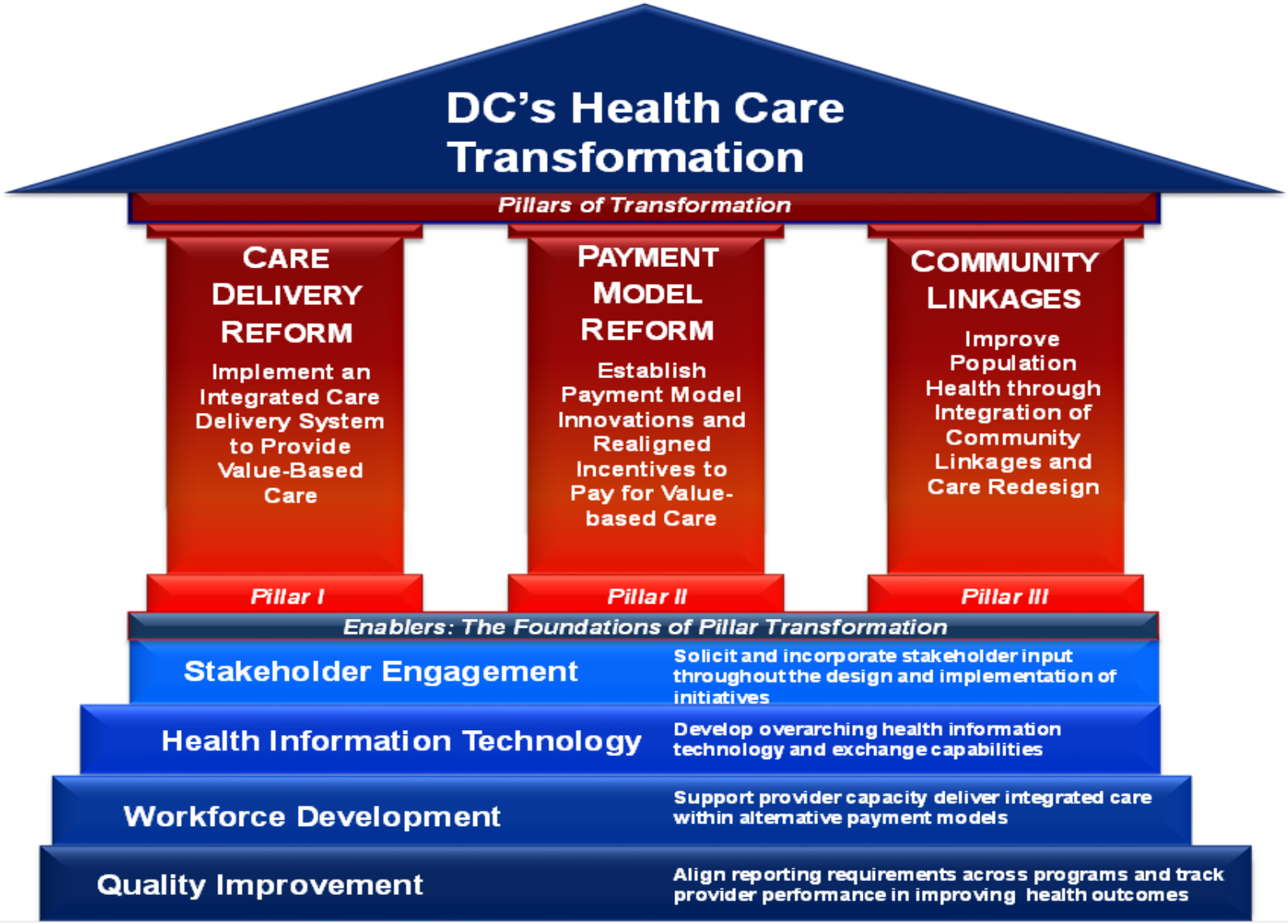
Access and acceptability of vendors for wheelchairs & other supplies greatly influence experiences in & opinions of the health system

Participants expressed the need for mental health services despite significant stigma regarding mental health remains

Five Aims of DC's SHIP



District's Health Care Transformation Pillars and Enablers



Pillar One: Care Delivery

Health Home 2 Development

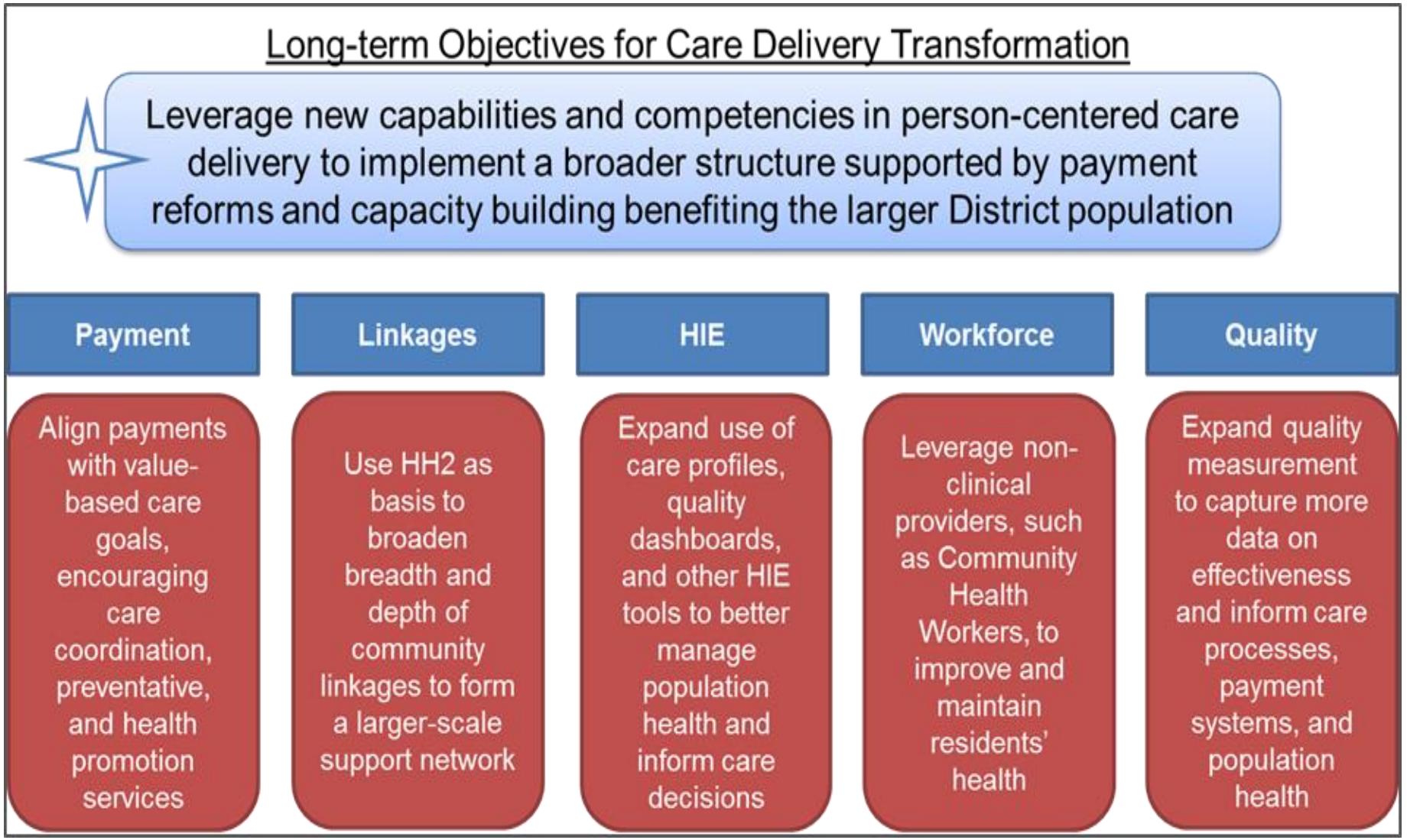
- **Target population:** ~25,000 beneficiaries (~2/3 FFS)

- **Eligibility:** 2 or more chronic conditions; or 1 chronic condition & historical chronic homelessness (i.e., matched to DC's Permanent Supportive Housing (PSH) program)*

- **Enrollment**: Patients will be assigned to a HH2 provider through an opt-out, with utilization trigger process. Patient attribution to HH2 provider will be based on a prior provider/patient relationship (2 year look-back), geography, provider capacity

- **Target Start Date:** January 2017

Care Delivery – Long-term Objectives for Transformation



Pillar Two: Payment Reform

Payment Reform Principles

- **Care Delivery Transformation**
  - Put the patient first and meet the patients where they are
  - Deliver the right care, right time, right place, right cost
  - Foster team-based care
  - Align across all providers (e.g. housing entities, behavioral health, etc.)
  - Include effective transitions of care, resourced at the provider level

- **Infrastructure/ Resources to Support Care Delivery Transformation**
  - Develop more integrated system(s) that aim to eliminate disparities and reduce inappropriate utilization of services
  - Share information that is accurate, actionable and accessible
  - Leverage existing strategies/resources
  - Align financial incentives with health system goals (e.g. shared accountability)

- **District's Transformation Process**
  - Allow all options to remain on the table
  - Be bold, but thoughtful with the timeline

Payment Model – Roadmap for Transformation

	2017	2018	2019	2020	2021
Key Activities	• Baseline year	Year 1 of P4P payments	Menu of Payment Options (P4P, APMs)		
Base Payment	Enhanced FFS		• Enhanced FFS; or • APM (e.g. Shared Savings; Full-Risk)		
Supplemental Payment(s)	• Care Coordination Payments (HH1, HH2, EPD, DD, MCO) • P4P (e.g. bonuses and/or penalties related to readmission rates, preventable IP/ED use, hospital acquired conditions) • Other (e.g. partnership with Hospital ACO)				
Capacity Building	• Health Information Exchange (e.g. IAPD tools) • Health Home 1 and 2 (e.g. flexible PMPM dollars) • Accountable Health Communities (e.g. screening/referral resource) • Lump Sum Payment for APM/Capacity Building (see Medicare)				
Outcomes	Set baseline for LANE, Re-admissions, and IP measures	Set reduction targets (%)	• Reset baseline • Add measures based on data/priorities	Reset baseline	Reset baseline
Non-Traditional FFS Payments	• 0% APM • 30% tied to value	• 20% APM • 50% tied to value	• 30% APM • 70% tied to value	• 50% APM • 90% tied to value	

Pillar Three: Community Linkages

Proposed Recommendations

- **Social Determinants of Health (SDOH):** SDOH impact the degree of health disparities experienced in DC, resulting in negative health outcomes acutely felt in particular geographic areas

- **Interdisciplinary Teams:** By building linkages within interdisciplinary team of clinical and health-related social services, the District can address SDOH and improve health outcomes and health status

- **Key Initiatives to Support Community Linkages:** Collaboration between clinical and health-related social services will be enabled by Health Homes model, Accountable Health Communities, health information technology, and an updated referral process

Enabler A: Stakeholder Engagement

Proposed Recommendations

- **Leverage established work groups and boards**
- **Renovate SIM Website**
- **Continue to distribute SIM Newsletter**
- **Improve Literacy:** Develop strategies to bolster benefits, public health and health system literacy
- **Patient Engagement:** Use Ombudsman Office for best practices for patient engagement strategies also utilize patient surveys
- **Patient Accountability:** Empower and incentivize patients to take responsibility of their health care decisions

Enabler B: HIT/HIE

Proposed Recommendations

- **Comprehensive data map:** Detail the flows of information among & between HIE users; Identify current gaps in DC's HIE landscape
- **HIE designation process**: Create a set standards for HIEs in DC related to interoperability, privacy, etc.
- **DC's Centralized Data Warehouse**: Increase the capacities & capabilities of repository for claims, health outcomes & admin. data for use via HIEs
- **Expanded HIE functionality**: Launch tools/initiatives that bolster DC's HIE usefulness including:
  - *Patient Care Profile*
  - *eCQM Tool & Dashboard*
  - *OB/Prenatal Registry*
  - *Analytical Population Dashboard*
  - *Ambulatory provider support*

Enabler C: Workforce Development

Proposed Recommendation

- **Development**: A well-developed and well-trained workforce is essential for implementing and sustaining short- and long-term transformation initiatives, especially for care delivery reform and enhancing community linkages

- **Capacity Building:** Establish methods for building new and existing workforce capacity through:
  - technical assistance and training,
  - investing in non-clinical communication and collaboration between clinical and health-related social services, and
  - Stimulating a holistic approach to care though payment reform

Enabler D: Quality Improvement

Proposed Recommendations

- Develop core measure set that aligns with existing performance reporting initiatives and represents priority topic areas in the District
- Obtain buy-in from commercial payers
- Build quality reporting in HIE
  - Implement a practice- and population-level dashboard
  - Ability to view measure data specific to their attributed patients, both on an individual and/or practice level
- Leverage existing dashboards (i.e., DC HP2020) to monitor population health

SHIP Development Timeline

Interim SHIP Report

- **5/11/16 –** Present to Advisory Committee
- **6/03/16** - Send updated Interim SHIP to Advisory Committee
- **6/12/16 –** Finalize Interim SHIP
- **6/13/16 –** Begin Public Comment Period on Revised Draft
- **7/05/16** – Public Comment Close

Final SHIP Report

- **7/13/16 –** Final Advisory Committee Meeting to Review Final SHIP
- **7/31/16 –** Submit SHIP to CMS